PRINT CLEAR

For DWC only: MPN Approval Number	Date Application Received: / /

Cover Page for Medical Provider Network Application

1. Name of MPN Applicant_____

2. Address

_____

_____

3. Tax Identification Number

__ __ -- __ __ __ __ __ __ __

4.Type of MPN Applicant

☐ Self-Insured Employer ☐ Group of Self-Insured Employers

☐ Self-Insurer Security Fund ☐ Joint Powers Authority ☐ State ☐ Insurer

5. Name of Medical Provider Network(s), if applicable: _____

6. If the medical provider network is one of the following deemed entities, check the appropriate box:

☐ Health Care Organization (HCO)
☐ Health Care Service Plan
☐ Group Disability Insurer
☐ Taft-Hartley Health and Welfare Trust Fund

7. Name of entity, administrator or other third-party who prepared MPN Application on behalf of MPN applicant (if applicable): _____

8. Signature of authorized individual: "I, the undersigned officer or employee of the MPN applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and ability, the information included in this application is true and correct."

_____

Name of Authorized Individual Title Phone/Email

_____

Signature of Authorized Individual Date Signed

9. Authorized Liaison to DWC:

Name Title Organization Phone/Email

_____

Address Fax number

Submit an original Cover Page for Medical Provider Network Application with original signature, an original Application with the information required by Title 8, California Code of Regulations, section 9767.3 and a copy of the Cover Page and Application to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 420603, San Francisco, CA 94142.

[DWC Mandatory Form - Section 9767.4 - *09/15/05*]